**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-0943.M5**

MDR Tracking Number: M5-04-1162-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-19-03.

The IRO reviewed office visits, myofascial release, ultrasound, electric stimulation and hot/cold packs rendered from 1-8-03 through 4-30-03 that were denied based upon "V".

The IRO concluded that myofascial release, ultrasound, electric stimulation and hot/cold packs were not medically necessary. The IRO concluded that office visits rendered from 1-6-03 through 4-30-03 were medically necessary.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(r)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

On this basis, the total amount recommended for reimbursement ($720.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On March 2, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified above; therefore, the Medical Review Division will review these services per *Medical Fee Guideline.*

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ (Maximum Allowable Reimbursement) | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 1-6-03 | 99080-73 | $20.00 | $0.00 | F | $15.00 | Rule 129.5(d) | The MAR for work status report is recommended of $15.00. |
| 1-8-03 | 99080 | $70.00 | $1.50 | F | $50.00 for 1-2 pgs. $20.00 for additional pg. | Rule 133.106 | Narrative reports – The MAR for a three page narrative report is recommended of $70.00. |
| 4-17-03 | 97035 | $26.00 | $0.00 | No EOB | $22.00 | CPT Code Descriptor | The MAR for ultrasound is recommended of $22.00. |
| TOTAL | | | | | | | The requestor is entitled to reimbursement of **$107.00.** |

This Decision is hereby issued this 7th day of September 2004

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

**ORDER.**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 1-6-03 through 4-30-03 in this dispute.

This Order is hereby issued this 7th day of September 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

**Amended Letter**
**Note:** Decision

February 25, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-1162-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a repetitive injury on ___ to his left shoulder and neck. He saw a chiropractor for treatment and therapy and a pain management specialist for trigger point injections which gave maximum relief.

Requested Service(s)

Office visits, myofascial release, ultrasound, electrical stimulation, and hot/cold packs from 01/08/03 through 04/30/03

Decision

It is determined that the office visits from 01/08/03 through 04/30/03 were medically necessary to treat this patient’s condition. However, the myofascial release, ultrasound, electrical stimulation, and hot/cold packs from 01/08/03 through 04/30/03 were not medically necessary to treat this patient’s condition.

Rationale/Basis for Decision

The left shoulder MRI and CT scans revealed post-surgical distortion of the acromioclavicular joint. The cervical MRI was interpreted as normal. The patient’s problems continued and he requested a change of treating doctors and he was evaluated by this new provider on 10/22/03. Positive objective and subjective findings were present that necessitated initiation of a treatment program as passive and active therapy had not been previously attempted.

During the time period in question, the patient also saw a pain management specialist and was treated with medications and injections. The records indicate there was an initial trial of conservative passive care with a progression into active therapy. However, for an extended period of time, there was both passive and active therapy performed.

Chiropractic treatment guidelines allow for this type of treatment for this condition. Under normal conditions, two to four weeks of passive therapy is allowed from the date of his initial evaluation of 10/22/02. This is a more complicated case and therefore up to two months of passive therapy would be allowed. Passive care beyond 12/22/02 would not be warranted. Therefore, it is determined that the office visits from 01/08/03 through 04/30/03 were medically necessary. However, the myofascial release, ultrasound, electrical stimulation, and hot/cold packs from 01/08/03 through 04/30/03 were not medically necessary.

Sincerely,